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Connecticut State Medical Society
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160 St. Ronan Street, New Haven, CT 06511-2390 (203) 865-0587 FAX (203) 865-4997

Connecticut State Medical Society Testimony
House Bill 6530 An Act Concerning the Accessibility and Effectiveness of Consumer Report Cards and Transparency In Health Insurance Claims Date
Senate Bill 961 An Act Concerning Medical Malpractice Data Reporting
Senate Bill 962 An Act Concerning Wellness Incentives
Insurance and Real Estate Committee.
February 24, 2009

Senator Crisco, Representative Fontana and members of the Insurance And Real Estate Committee, on behalf of the more than 7,000 members of the Connecticut State Medical Society (CSMS) thank you for the opportunity to present this testimony to you today on **House Bill 6530 An Act Concerning the Accessibility and Effectiveness of Consumer Report Cards and Transparency in Health Insurance Data Claims.** This bill attempts to strengthen initiatives to provide consumers with reports about health centers, health insurers and the provider networks contracted with them. CSMS has regularly promoted and support these efforts in our State. This will provide greater access to information relevant and necessary for consumers, employers and physicians to make educated decisions regarding the purchasing of health insurance and provision of healthcare.

In general, the Bill will allow both employers and consumers to have better information about certain aspects of their respective relationships with their insurers. Relevant cost and reimbursement insurer information will be made available. While we welcome the opportunity to work with committees to strengthen appropriate reporting requirements, the language before you today appears confusing and without proper context or understanding of underlying circumstances may prove misleading to employers and consumers. For example, member utilization rates among doctors may seem very much askew, unless one is able to contextualize the relationship of the doctor to the member population.

Recently, CSMS has testified before you on similar bills to expand the consumer report card to include the medical loss ratio of medical liability insurers (Senate Bill 457 An Act Concerning Consumer Report Cards) and to strengthen the definition of medical loss ratio on (Senate Bill 46 An Act Concerning Transparency of Medical Loss Ratio Information). We suggest to the committee today that accepting our testimony on those bills that included the attached definitions related to medical loss ratios as developed by the AMA would allow this committee to accomplish the goal of HB 6530 in a more clear and concise manner.

CSMS has consistently supported the collection ad reporting of Medical Liability Closed Claims Data. CSMS supports the expansion of the current statute as would be required in **Senate Bill 961 An Act Concerning Medical Malpractice Data Reporting.** The legislation before you will capture a fast growing

entities that provide medical liability insurance to physicians; captive insurers or those who are self insured.

The affordability and accessibility of medical liability insurance continues to be a barrier for physicians in the state. Furthermore, reports by the Department of Insurance currently state that only approximately 50 percent of all closed claims in the State are reported by independent insurers required to file with DOI. However, in order to understand the volume, severity and full economic impact of closed medical liability claims all such claims in the state must be captured and analyzed. This legislation will expand the important process of evaluation and review.

In addition to expanding the entities required to report closed claims, SB 961 expands and clarifies reporting requirements and their definitions and establishes penalties for failure to comply with the act. Please support SB 961

CSMS is encouraged by the content of **Senate Bill 962 An Act Concerning Wellness Incentives.** As physicians, we continually emphasize the importance of wellness and support the use of any incentive that encourages our patients to lead a healthy life. Not only is this in the best interest of the patients, but will increase the health and quality of life for Connecticut residents. Furthermore, cost savings on over healthcare spending by reducing the expenses associated with many long term and more complex diagnosis as the result of unhealthy lifestyles will be realized.

We are pleased that the dialogue and discussion surrounding the provision of wellness incentives has elevated to this level. We welcome the opportunity to continue with efforts such as these to increase the overall health of Connecticut residents.

IN THE GENERAL ASSEMBLY

STATE OF_____

Health Insurance Premium Transparency Act

Section 1. Title.

Be it enacted by the People of the State of _____, represented in the General Assembly:

Section 2. Purpose.

(a) There is a vital need for employers and consumers to have a clear understanding of how health care premiums are allocated by health insurance companies ("insurers") in this state, and particularly how much of their premium dollars are spent on health care services as opposed to administration, profit, or for other purposes. Full transparency of how health care insurance premiums are spent will empower health insurance purchasers to make more informed decisions, and reward companies that minimize administrative waste;

(b) According to the Kaiser Family Foundation, since 1999, average premiums for family coverage have increased 119% - from $5,791 in 1999 to $12,680 in 2008. Worker premium contributions have similarly increased from $1,543 to $3,354;

(c) According to the Commonwealth Fund, the fastest rising component of health care spending is administrative overhead. Between 2000 and 2005, the net insurance administrative overhead, including both administrative expenses and insurance industry profits, increased by 12% per year. This increase is 3.4% points faster than the average health expenditure growth of 8.6%; and

(d) A minimum medical expense threshold is necessary to maximize the value of health insurance premiums, and an important step toward controlling spiraling health care costs, which are due, in part, to the dramatic rise in administrative costs and insurer profits.

Section 3. Definitions.

(a) "Medical expense" means the total amount of money that the insurer spends on direct medical care services for enrollees. This includes the total financial obligation for physician services, non-physician health care professional services, hospital and other health facility services, drugs and medical devices, and other health care services that the health insurer incurs on behalf of its enrollees. Medical expense does not include administrative costs.

(b) "Premiums" means the amount that the purchaser pays to the health insurer to purchase health care coverage.

(c) "Health Insurer" means any entity, including an insurance company authorized to issue health insurance, an Health Maintenance Organization (HMO), or any other entity providing a plan of health insurance, health benefit or health services, who is subject to the insurance laws and regulations of this state or subject to the jurisdiction of the Commissioner of Insurance of this State, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

(d) "Administrative Costs" include, but are not limited to, costs associated with claims processing, collection of premiums, marketing, operations, taxes, general overhead, salaries and benefits, quality assurance, utilization review and management, pharmacy and other benefit management, network contracting and management, and state and federal regulatory compliance.

(e) "Medical Expense Threshold" means the quotient, to the nearest one percent, of the total medical expenses divided by the total premiums.

(e) "Multiple Employer Arrangement" means an arrangement established or maintained to provide health benefits to employees and their dependents of two or more employers, under an insured plan. In a multiple employer arrangement, the employer assumes all or a substantial portion of the risk and shall include, but is not limited to, a multiple employer welfare arrangement, multiple employer trust or other form of benefit trust.

(f) "Interest" means the interest earned on the premiums by the insurer.

Section 4. Annual Premium Transparency Report.

(a) Requirement to Report How Health Insurance Premiums Are Spent. Insurers shall report how health care premiums are spent no later than March 1 of each year for the premiums earned for the immediately preceding calendar year. The annual report required by this section shall include the insurer's calculation of any dividends or credits, as well as an explanation of the insurer's plan to issue dividends or credits.

(b) Report Contents. Insurers shall report how health insurance premiums were spent for each of the following categories of insurance provided by the insurer: Preferred Provider Organization (PPO), HMO, Point of Service (POS) and High Deductible Health Plan (HDHP). This report shall include the following information for each category of insurance:

(1) A specific breakdown of administrative costs as follows:

i) CEO and executive salaries;

ii) Non-executive salaries, wages, and other benefits;

iii) Commissions;

iv) Consulting fees;

v) Pharmacy benefit management;

vi) Utilization review management;

vii) Marketing expenses;

viii) Insurance, including the following categories of commercial insurance:

a) Reinsurance;

b) General liability;

c) Professional liability insurer;

d) Other insurance types;

ix) Taxes, including:

a) State and local insurance;

b) State premium;

c) Payroll;

d) Federal and state income;

e) Real estate;

f) Other taxes;

x) Travel expenses;

xi) Rent and real estate expenses;

xii) Certification, accreditation, board, bureau and association fees;

xiii) Auditing and actuarial fees;;

xiv) Collection and bank service charges;

xv) Occupancy, depreciation and amortization;

xvi) Cost or depreciation of electronic data processing, claims and other services;

xvii) Postage, express, telephone, printing, office supply and equipment fees;

xviii) Regulator authority licenses and fees;

xix) Investment expenses not included elsewhere;

xx) Aggregate write-ins for expenses;

(2) The reporting insurer's name and address;

(3) The insurer's total earned premiums, before dividends or credits applicable to prior years;

(4) The amount of interest earned on premiums for the preceding calendar year;

(5) The total medical expense incurred during the preceding calendar year;

(6) Certification by a member of the American Academy of Actuaries that the information provided in the report is accurate and complete and that the insurer is in compliance with this Act and regulations promulgated by this Act; and

(7) Such other information as the (applicable state agency) may request.

(c) Public Record. All data or information required to be filed with (applicable state agency) pursuant to the Act shall be made public record.

Section 5. Medical Expense Threshold Percentage Requirements.

(a) Insurers must direct 80% of health insurance premiums towards medical expense for individual and small employer products and 85% for large employer products.

(b) Report Instructions and Methodology. The instructions and methodology for calculating and reporting medical expense threshold levels and issuing dividends or credits shall be specified by the (applicable state agency).

Section 6. Dividend or Credit Distribution.

(a) Distribution of Dividend or Credit for Failure to Comply with Medical Expense Threshold. In each case where the insurer fails to comply with the medical expense threshold requirements set forth in this Act, the insurer shall issue a dividend or credit toward future premiums for the policyholder that is not less than an amount that would meet the applicable minimum requirement.

(b) Regulatory Approval Necessary Prior to Distribution of Dividend or Credit. Prior to distributing any dividend or credit, an insurer must provide the (applicable state agency) with its plan for the distribution of all required dividends and credits as part of the required annual medical expense threshold. No distributions of required dividends or credits may be made without prior approval from (applicable state agency).

(c) Calculation of Dividends or Credits. The dividend or credit required to be distributed pursuant to this Act shall be determined by the (applicable state agency).

(d) Distributions to Any Covered Employer. The distribution of dividends or credits required under this law shall be made to each employer that was covered for any period in the preceding calendar year.

(e) Distribution to Employers. Insurers that issue health insurance policies through out-of-state trusts, purchasing alliances or other group purchasing organizations, associations or other multiple employer arrangements shall specify in the plan for distribution of dividends or credits that the dividends or credits for such health insurance policies shall be paid or credited, as applicable, to the covered employers, not the trust, association, purchasing alliance or other group purchasing organization, or other multiple employer arrangement.

(f) Reporting of Distribution If an insurer is required to issue a dividend or credit, the insurer shall include the insurer's calculations of the dividend or credits to be issued due to failure to satisfy the minimal medical expense ratio threshold, and an explanation of the insurer's plan to issue these dividends and credits, in its Premium Transparency Report.

Section 7. Compliance Audit.

The (applicable state agency) has the authority to perform an audit of any insurer. If the audit shows that an insurer has violated any part of this law, the insurer will be subject to the appropriate penalties and fines.

Section 8. Penalties for Violating Reporting Requirements.

Any insurer failing to comply with the requirements of this Act, or of any rules promulgated pursuant to the Act, will be subject to a fine of no less than $1,000, and no more than $10,000, per day of violation.

Section 9. Consumer and Employer Rights.

Any consumer, employer, or their representatives, from seeking enforcement of this Act or any regulations promulgated under the Act.